National Naval Medical Center-Bethesda
HIPAA Patient Complaint Form

Today's Date:_____

Name:_____
(*If same as beneficiary please skip next blank*)

Beneficiary's Name:_____

Address: _____

Phone/Email: (000) 000-0000 your_email@your_isp

Date of Occurrence:_____

Place of Occurrence:_____

Concern(s) *(How was the patient's protected health information (PHI) violated?)*:_____

Submitted By:
Name:_____ **Location:**_____

Contact Number: (000) - 000 - 0000

Signed:_____**Department:**_____

Return this form to:

HIPAA Privacy Office
Attn.: LTJG Heather Taylor
National Naval Medical Center
8901 Wisconsin Avenue
Building 10, Deck 1 (1st Floor), Room 1131
Bethesda, Maryland 20089-5600
Phone: (301) 295-0991
Email: – NNMC-HIPAA@bethesda.med.navy.mil

Action Taken (For Internal Use Only):_____